

Accepted 6/16/09 Sciana

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN4883AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2009
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN ADULT FAMILY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 973 LEPORI WAY SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on June 10, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and six employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 274 SS=E	449.2175(5) Service of Food - Substitutions NAC 449.2175 5. Any substitution for an item on the menu must be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous place during the service of the meal. This RULE: is not met as evidenced by:	Y 274	The Administrator will assign the caregiver #6, who is also the manager of the company, facility to be in-charge of documenting the substitution for the items on the menu for the residents #2 and #5 who have special diet orders. The caregiver #6 will document the substitution of the items on the menu weekly and the menu will be posted in the conspicuous place in the dining area. The Administrator	6/15/09

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

06/15/09

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Y 274	Continued From Page 1 Based on record review and interview on 6/10/09, the facility failed to document menu substitutions for 2 of 5 residents (Residents #2 and #5). Severity: 2 Scope: 2	Y 274	<i>will check and monitor the process on a regular basis and will keep the records of the menu on file for at least 90 days</i>	
Y 944 SS=A	449.2749(2) Resident File / Discharge NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death. This RULE: is not met as evidenced by: Based on record review and interview on 6/10/09, the facility did not provide proper documentation regarding a resident who had expired or had been discharged (Resident #6). Severity: 1 Scope: 1	Y 944	<i>A Discharge or Transfer form (attachment #1) was generated and will be utilized whenever a resident of the facility is discharged, transferred, or dies in the facility. The above form will be completed by the Administrator and will be attached to the chart of the resident who is discharged, transferred, or dies in the facility</i>	<i>06/15/09</i>

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